Provider Participation Requirements (RTS)

Last Updated: 05/10/2022

Table of Contents

Provider Participation Requirements (RTS)

PROVIDER PARTICIPATION REQUIREMENTS

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the fee for service (FFS) behavioral health benefits program under contract with DMAS. Providers are responsible for adhering to this manual, available on the DMAS website portal, and all DMAS policies, their Magellan of Virginia provider contract and policies, and related state and federal regulations.

Magellan of Virginia is authorized to create, manage, enroll, and train a FFS provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan of Virginia's authority shall include entering into or terminating contracts with providers and imposing sanctions upon providers as described in any contract between a provider and Magellan of Virginia. The provider network is managed and maintained by Magellan of Virginia. Magellan of Virginia is responsible for enrollment and credentialing of FFS behavioral health providers into the network based upon DMAS regulatory requirements and geographical access needs. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

Providers under contract with Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/provide.

All calls related to the FFS behavioral health services should go to the Magellan of Virginia Call Center. Magellan of Virginia staff is available to assist callers with:

- service authorizations,
- clinical reviews,
- member eligibility status,
- referrals for services,
- provider network status,
- claims resolution,

- grievances and
- complaints.

MANAGED CARE ENROLLED MEMBERS

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check eligibility (Refer to Chapter 3) prior to rendering services to confirm whether an individual is enrolled in a Medicaid MCO and which particular MCO.

DMAS OFFERS A WEB-BASED INTERNET OPTION TO ACCESS INFORMATION REGARDING MEDICAID OR FAMIS MEMBER ELIGIBILITY AND MCO ENROLLMENT. PROVIDERS MUST REGISTER THROUGH THE VIRGINIA MEDICAID WEB PORTAL IN ORDER TO ACCESS THIS INFORMATION. THE VIRGINIA MEDICAID WEB PORTAL CAN BE ACCESSED BY GOING TO: WWW.VIRGINIAMEDICAID.DMAS.VIRGINIA.GOV. IF YOU HAVE ANY QUESTIONS REGARDING THE VIRGINIA MEDICAID WEB PORTAL, PLEASE CONTACT THE CONDUENT GOVERNMENT HEALTHCARE SOLUTIONS SUPPORT HELP DESK TOLL FREE, AT 1-866-352-0496 FROM 8:00 A.M. TO 5:00 P.M. MONDAY THROUGH FRIDAY, EXCEPT HOLIDAYS. THE MEDICALL AUDIO RESPONSE SYSTEM PROVIDES SIMILAR INFORMATION AND CAN BE ACCESSED BY CALLING 1-800-884-9730 OR 1-800-772-9996. BOTH OPTIONS ARE AVAILABLE AT NO COST TO THE PROVIDER.

Even if the individual is enrolled with an MCO, some services, such as therapeutic group home (TGH) services, continue to be covered by Medicaid Fee-for-Service (FFS). Providers must follow the Fee-for-Service rules in these instances where services are “carved-out.” Refer to each program’s website for detailed information and the latest updates. While youth residing in TGHs remain in managed care, youth who enter a psychiatric residential treatment facility (PRTF) are disenrolled from managed care.

There are several different Medicaid managed care programs (Medallion 4.0, CCC Plus, and PACE). For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO’s network. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

- Medallion 4.0:

  http://www.dmas.virginia.gov/#/med4

- Commonwealth Coordinated Care Plus (CCC Plus):

  http://www.dmas.virginia.gov/#/cccplus

- Program of All-Inclusive Care for the Elderly (PACE)

http://www.dmas.virginia.gov/#/longtermprograms

Provider Qualifications (RTS)

Provider Credentials for Mental Health Services Staff:

Residential treatment service providers (PRTFs and TGHs) must ensure that employed or contracted staff meet the service-specific staff requirements of all services rendered by the service provider. All provider sites must be credentialed by Magellan of Virginia, licensed by the Department of Behavioral Health and Developmental Services (DBHDS) and in compliance with all DMAS requirements as defined in the residential treatment service regulations.

"ADL Supervisor" means a child care supervisor with a baccalaureate degree in social work or psychology and two years of professional experience working with children one year of which must have been in a residential facility for children; or a high school diploma or General Education Development Certificate (G.E.D.) and a minimum of five years professional experience working with children with at least two years in a residential facility for children; ADL supervisors shall work under supervision of the Program Director.

"ADL Technician" means a child care worker at least 21 years of age who has a baccalaureate degree in human services; has an associate's degree and three months experience working with children; or is a high school graduate or has a G.E.D. and has six months of experience working with children. A trainee with a high school diploma or a G.E.D may gain experience working with children by working directly alongside a staff member who is, at a minimum, an ADL technician with at least one year of professional experience with children. These trainees must be within sight and sound of the supervising staff member and may not work alone. ADL technicians must be supervised by an ADL supervisor, QMHP-C, LMHP, LMHP-R, LMHP-RP or LMHP-S.

“Institution for Mental Disease” or **“IMD”** means a hospital, nursing facility, or other institution with more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

"Licensed assistant behavior analyst" or **“LABA”** means a person who has met the licensing requirements for an assistant behavior analyst as defined in 18VAC85-150-10 et seq. and holds a valid license issued by the Virginia Board of Medicine.

"Licensed behavior analyst" or **“LBA”** means a LMHP who has met the licensing requirements for a behavior analyst as defined in 18VAC85-150-10 et seq. and holds a valid license issued by the Virginia Board of Medicine.

"Licensed mental health professional" or **"LMHP"** means the same as defined in 12VAC35-105-20.

"LMHP-resident" or **"LMHP-R"** means the same as "resident" as defined in (i) 18VAC115-20-10 for licensed professional counselors; (ii) 18VAC115-50-10 for licensed marriage and family therapists; or (iii) 18VAC115-60-10 for licensed substance abuse treatment practitioners. An LMHP-resident shall be in continuous compliance with the regulatory requirements of the applicable counseling profession for supervised practice and shall not perform the functions of the LMHP-R or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Counseling.

"LMHP-resident in psychology" or **"LMHP-RP"** means the same as an individual in a residency, as that term is defined in 18VAC125-20-10, program for clinical psychologists. An LMHP-resident in psychology shall be in continuous compliance with the regulatory requirements for supervised experience as found in 18VAC125-20-65 and shall not perform the functions of the LMHP-RP or be considered a "resident" until the supervision for specific clinical duties at a specific site has been preapproved in writing by the Virginia Board of Psychology.

"LMHP-supervisee in social work," "LMHP-supervisee" or **"LMHP-S"** means the same as "supervisee" as defined in 18VAC140-20-10 for licensed clinical social workers. An LMHP-supervisee in social work shall be in continuous compliance with the regulatory requirements for supervised practice as found in 18VAC140-20-50 and shall not perform the functions of the LMHP-S or be considered a "supervisee" until the supervision for specific clinical duties at a specific site is preapproved in writing by the Virginia Board of Social Work.

“Program Director” means the same as defined in 12VAC35-46-350.

"Qualified mental health professional-child" or **"QMHP-C”** means the same as the term is defined in § 54.1-3500.

"Qualified mental health professional-eligible" or **"QMHP-E"** means the same as the term “qualified mental health professional - trainee” as defined in § 54.1-3500.

The QMHP-E staff must have at least one hour of supervision per week by a LMHP, LMHP-R, LMHP-S or LMHP-RP which must be documented in the employee file. Evidence of compliance with the QMHP-E criteria must be in the staff file.

"Qualified paraprofessional in mental health" or **"QPPMH"** means the same as the term is defined in 12VAC35-105-20.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

PRTF services shall be covered for the purpose of diagnosis and treatment of mental health and behavioral disorders when such services are rendered by PRTFs. This section also applies to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) PRTFs. PRTFs must be:

- licensed by The Department of Behavioral Health and Developmental Services (DBHDS);

- accredited by the Joint Commission on Accreditation of Healthcare organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children or by any other accrediting organization with comparable standards that is recognized by the state; and
- fully in compliance with (i) the Code of Federal Regulations at 42 CFR Part 441 Subpart D, specifically 42 CFR 441.151 (a) and (b) and 441.152 through 441.156, and (ii) the Conditions of Participation in 42 CFR Part 483 Subpart G regarding the use of restraint and seclusion.

Each admission must be service authorized and the treatment must meet DMAS requirements for clinical necessity as outlined in Chapter IV of this manual.

THERAPEUTIC GROUP HOME (TGH)

TGH service providers shall be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) under the Regulations for Children's Residential Facilities (12VAC35-46). Service Providers must be credentialed and contracted with Magellan of Virginia. Licensed practitioners providing professional services separately from the TGH per diem shall also be credentialed and contracted with the youth's MCO. This section also applies to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) TGHs.

- Room and board costs shall not be reimbursed. Facilities that only provide independent living services or non-clinical services that do not meet the requirements of this subsection are not eligible for reimbursement.
- DMAS shall reimburse only for services provided in facilities or programs with no more than 16 beds regardless of the funding source. DMAS shall not reimburse for TGH services provided in any facility that meets the definition of an Institution for Mental Disease (IMD).
- TGH services may only be rendered by a LMHP, LMHP-S, LMHP-R, LMHP-RP, a QMHP-C, a QMHP-E, a QPPMH, an ADL Supervisor or an ADL Technician.
- Treatment Team/Team Responsible for the Plan of Care must contain an LMHP, LMHP-R, LMHP-RP, or LMHP-S and a family member or legally authorized representative.
- The clinical director must be a LMHP. The caseload of the clinical director must not exceed 16 total clients including all sites for which the clinical director is responsible;
- The program director must be full time and meet the requirements for a program director as defined in 12VAC35-46-350.
- Assessment, treatment planning, crisis management, and individual, group and family therapy must be provided by a LMHP, LMHP-S, LMHP-R, or LMHP-RP.

- Skills restoration must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-C, QMHP-E or QPPMH under the supervision of a QMHP-C or higher.
- ADL restoration must be provided by a: LMHP, LMHP-R, LMHP-RP, LMHP-S or QMHP-C; or, a QMHP-E, QPPMH, ADL Supervisor or ADL Technician under the supervision of a QMHP-C or higher.
- At least 50% of the direct care staff onsite at the group home must meet a minimum of DBHDS QPPMH criteria.
- Services provided by QPPMHs require supervision by a QMHP-C or higher. Supervision is demonstrated by the supervisor's review of progress notes, the member's progress towards achieving Comprehensive Individual Plan of Care (CIPOC) goals and objectives, and recommendations for change based on the youth's status. Supervision must occur and be documented monthly in the clinical record.
- Direct staff who do not meet the minimum QPPMH requirements may provide services for Medicaid reimbursement if they meet qualifications to be an ADL Supervisor or ADL Technician, are working directly with at least a QPPMH on-site and being supervised by a QMHP-C or higher. Supervision must include on-site observation of services, face-to-face consultation with the direct staff member, a review of the progress notes, the youth's progress towards achieving CIPOC goals and objectives, and recommendations for change based on the youth's status. Supervision must occur and be documented monthly in the clinical record.
- If any services are subcontracted, the subcontracted provider must meet the same qualifications as listed in this chapter for program operation and provider qualifications. The provider who subcontracts services is responsible for ensuring that the subcontracted employees meet all psychiatric service requirements and psychiatric services staffing requirements.

EPSDT PRTFs and TGHs

For Applied Behavior Analysis (ABA) services delivered in EPSDT PRTFs and TGHs, the following requirements apply:

- Applied Behavior Analysis (ABA) Services must be provided by either:
    1. An LMHP practicing within the scope of their practice as defined by the applicable Virginia Health Professions Regulatory Board or an agency that employs a LMHP, or
    2. An LBA meeting all requirements established by the Virginia Board of Medicine in 18VAC85-150-10 et seq. or an agency that employs a LBA.

- Direct ABA interventions must be provided by either:

1. A LMHP acting within the scope of their practice;
2. A LMHP, LMHP-R, LMHP-RP or LMHP-S;
3. A LBA;
4. A LABA under the supervision of a LBA; or
5. Personnel under the supervision of a LBA in accordance with 18VAC85-150-10 et seq. of the Virginia Board of Medicine regulations.

- EPSDT PRTF and TGH providers practicing ABA must meet all requirements established by the Virginia Board of Medicine in 18VAC85-150-10 et seq.

Independent Assessment, Certification and Coordination Teams (IACCT)

a. The independent certification team shall certify the need for PRTF or TGH services and issue a certificate of need document within the process and timeliness standards as approved by DMAS under contractual agreement with Magellan of Virginia.

b. The independent certification team shall be approved by DMAS through a Memorandum of Understanding with a locality or be approved under contractual agreement with Magellan of Virginia. The team shall initiate and coordinate referral to the FAPT (as defined in Va. Code 2.2-5207 and 2.2-5208) to facilitate care coordination and for consideration of educational coverage and other supports not covered by DMAS.

c. The independent certification team shall assess the individual's and family's strengths and needs in addition to diagnoses, behaviors, and symptoms that indicate the need for behavioral health treatment and also consider whether local resources and community-based care are sufficient to meet the individual's treatment needs, as presented within the previous 30 calendar days, within the least restrictive environment.

For additional information on the IACCT process and IACCT team requirements, please

refer to the IACCT supplement to this manual.

Level A Group Home Level of Care (Service ended April 30, 2018)

As of May 1, 2018, DMAS ceased reimbursement for TGH services provided by a DSS licensed facility. Level A providers who were contracted with Magellan of Virginia had until April 30, 2018 to obtain a conditional license as defined by DBHDS in 12VAC35-46-90.

Freedom of Choice (RTS)

The individual has the right to choose to receive services from any Medicaid-enrolled provider of services. However, payments under the Medical Assistance Program are limited to providers who meet the provider participation standards and who have signed a written agreement with the Department of Medical Assistance Services. Fee for service providers must have a signed provider contract with Magellan of Virginia, meet the appropriate credentialing requirements, and adhere to Magellan of Virginia policies and procedures.

Provider Enrollment (RTS)

Each provider of TGH and PRTF services must be credentialed and contracted with Magellan of Virginia prior to billing for any services provided to Medicaid enrolled individuals.

DMAS is informing the provider community that National Provider Identifier numbers (NPIs) may be disclosed to other Healthcare Entities pursuant to CMS guidance. The NPI Final Rule requires covered healthcare providers to disclose their NPIs to any entities that request the NPIs for use of the NPIs in HIPAA standard transactions. DMAS may share a provider's NPI with other healthcare entities for the purpose of conducting healthcare transactions, including but not limited to Referring Provider NPIs and Prescribing Provider NPIs.

As part of the supporting documentation for a PRTF provider, Magellan of Virginia must receive a signed letter of attestation from the Chief Executive Officer (CEO) of the facility stating that the facility is in compliance with the federal condition of participation of restraint and seclusion in PRTFs (42 CFR §§ 483.350 – 483.376). If there is a change in CEOs, a new letter of attestation must be submitted. Letters are required at enrollment and annually thereafter. A sample letter of attestation can be found in the Exhibits section at the

end of this chapter. Letters are due by 5 PM on July 1 or the first business day thereafter each year.

Adherence to the regulations regarding restraint & seclusion, including the reporting of any serious incident involving any individual, is a condition of continued participation as a Medicaid provider. If the letter of attestation is not received by Magellan of Virginia by the due date, approval of new authorizations will not occur. Also, DMAS Utilization Review Audits will monitor for compliance with the provider contract with Magellan of Virginia.

For further information on requirements related to restraint and seclusion, refer to Chapter IV of this manual.

Instructions for billing and specific details concerning the Medicaid Program are contained in this manual. Providers must comply with all sections of this manual, their contracts, and related state and federal regulations to maintain continuous participation in the Medicaid Program.

Out-of-State Facilities

Enrollment of providers for PRTFs and TGHs are generally limited to those located in Virginia or within 50 miles of the state line. If a youth requires this level of service that is not available in Virginia, an out-of-state provider may enroll for a specific youth only for the duration of the admission. Out-of-state providers or Children's Services Act Coordinators who are interested in obtaining Virginia Medicaid reimbursement for a specific youth may contact Magellan of Virginia and provide information.

Specific information required for out-of-state placement consideration:

- Referral source and contact person
- Name and contact information, such as website, of the proposed placement
- Basic demographics of the youth (age, sex, current location, family involvement, Medicaid number)

- Description of the youth's current need for intensive PRTF services, such as planned focus of treatment, problem behaviors, DSM diagnosis, medications, court involvement, previous treatments-successful or not, discharge summaries (within the past 6 months)
- Virginia Medicaid providers approached to access services for the youth and the outcomes (provide specific reasons for denial of admission)
- Discharge plan

Specific Information for Out-of-State Providers

Out of state providers are held to the same service authorization processing rules as in-state providers and must have an agreement with Magellan of Virginia prior to submitting a request for out of state services for a specific youth which will cover enrollment only for the duration of the admission to Magellan of Virginia. If the provider is not enrolled as a participating provider, the provider is encouraged to submit the request to Magellan of Virginia as timeliness of the request will be considered in the review process. Magellan of Virginia will complete the service authorization review and will request the completion of enrollment documentation.

If Magellan of Virginia receives the information in response to the provider's enrollment, the request will be completed and the provider will be informed of the status of their enrollment to serve the individual youth.

If Magellan of Virginia does not receive the information to complete the processing of enrollment within 12 business days, Magellan of Virginia will reject the service authorization request and will not enroll the provider. It may take up to 10 business days after the receipt of required documentation to become a participating provider that is only serving a specific youth during the duration of admission.

Requests for Enrollment (RTS)

All providers who wish to participate with Virginia Medicaid are being directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for

submission. Please go to www.virginiamedicaid.dmas.virginia.gov to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

Providers that wish to serve fee for service members for behavioral health services must contract with Magellan of Virginia.

Provider Screening Requirements

All providers must now undergo a federally mandated comprehensive screening before their application for participation is approved by DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as “limited”, “moderate” or “high”. Please refer to the table at the end of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment

criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the "high" level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers are required to pay an application fee. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. **The application fee requirements are also outlined in Appendix section of this provider manual.**

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied.

An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously

mentioned above, then the application will be rejected.

Revalidation Requirements (RTS)

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via DMAS' web portal or notice from Magellan for providers that are contracted with Magellan Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS and Magellan may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS (RTS)

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not

been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

PARTICIPATION REQUIREMENTS (RTS)

To be a network provider of FFS behavioral health services with Magellan of Virginia to serve members in the Virginia Medicaid/FAMIS programs, you or your agency must be credentialed and enrolled according to Magellan of Virginia and DMAS standards, and must be contracted with Magellan of Virginia. Providers are subject to applicable licensing requirements. Additionally, any licensed practitioner joining a contracted group practice or a contracted organization adding a newly licensed location must also become credentialed with Magellan of Virginia prior to rendering services. To initiate the application process, providers can visit www.magellanofvirginia.com and click the "Join the Network" link under the *For Providers* tab on the homepage. Additional information regarding the credentialing criteria and contracting process can be reviewed in the Provider Handbook Supplement for Virginia Behavioral Health Service Administrator located at www.magellanofvirginia.com and click "Provider Handbook" link under the *For Providers* tab on the homepage.

All participating Medicaid providers are required to complete a new contract agreement as a result of any name change or change of ownership.

Upon completion of the enrollment process, a ten-digit Atypical Provider Identifier (API) will be assigned as the provider identification number for non-healthcare providers. Healthcare providers are required to submit their National Provider Identifier (NPI) number. The API or NPI number must be used on all claims and correspondence submitted to Magellan of Virginia.

For any additional questions about credentialing and contracting, providers may contact a Magellan of Virginia Provider Network Coordinator at 1-800-424-4536, or send an email to VAProviderQuestions@MagellanHealth.com

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. Behavioral Health providers approved for participation in the Magellan of Virginia provider network must perform the following activities as well as any others specified by DMAS. Requirements for providers approved for participation include, but are not limited to, the following:

- Immediately notify Magellan of Virginia in writing whenever there is a change in the information that the provider previously submitted, including adding new services, new service locations or changes in licensure. For a change of address, notify Magellan of Virginia prior to the change and include the effective date of the change;

- Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as Magellan of Virginia requires, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.

- Send updated staff rosters no less than quarterly;

- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;

- Assure the individual's freedom to reject medical care and treatment;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;

- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;

- Provide services and supplies to individuals of the same quality and in the same mode

of delivery as provided to the general public;

- Charge Magellan of Virginia for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;

- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party;

- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable cost. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency …." The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge DMAS, Magellan of Virginia or an individual for broken or missed appointments;

- Accept assignment of Medicare benefits for eligible Medicaid enrolled individuals;

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;

- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;

- Use DMAS or Magellan of Virginia designated billing forms for submission of charges;

- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided; In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;

- Disclose, as requested by DMAS or its contractor, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members;

- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public; and

- Serious incidents involving any youth must be reported to Magellan of Virginia, DBHDS Licensing, and the Disability Law Center of Virginia (DLCV), the protection and advocacy system for persons with disabilities in the Commonwealth of Virginia. Serious incidents include a youth's death, suicide attempt, or a serious injury that requires medical attention. The incident does not need to be related to a restraint or seclusion. If a youth must go to the emergency room to address an injury while a resident of the facility, the report must be sent to Magellan of Virginia. Providers contracted with Magellan of Virginia should send incident reports by fax at 1-888-656-5396.

  The fax must include the following information:

- Youth's name and Medicaid number;
- Facility name, address, and NPI number;
- Names of staff involved;
- Detailed description of the incident, including the date and location
- of the incident;
- Outcome, including the persons notified; and
- Current location of the youth.

Provider Responsibilities to Identify Excluded Individuals and Entities

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS
Attn: Program Integrity/Exclusions
600 E. Broad St, Ste 1300
Richmond, VA 23219

E-mailed to: providerexclusions@dmas.virginia.gov

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's signature on the claim indicates their attestation of compliance with the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding non-compliance with these requirements.

Utilization of Insurance Benefits

Virginia Medical Assistance Programs are "last pay" programs. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs, other insurance, or third party liability. Health, hospital, Workers' Compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- **Title XVIII (Medicare)** - Virginia Medical Assistance Program will pay the amount of any deductible or co-insurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No Virginia Medical Assistance Program payments shall be made for a patient covered by Workers' Compensation.
- **Other Health Insurance** - When a consumer has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Virginia Medical Assistance Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.
- **Liability Insurance for Accidental Injuries** - DMAS will seek repayment from any settlements or judgments in favor of Medicaid/FAMIS/FAMIS MOMS recipients who receive medical care as the result of the negligence of another. If a recipient is treated as the result of an accident and DMAS is billed for this treatment, DMAS should be notified promptly so action can be initiated by DMAS to establish any lien that may exist under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third-party carrier or file a lien in

lieu of billing DMAS.
- If there is an accident in which there is a possibility of third-party liability or if the recipient reports a third-party responsibility (other than those cited on his or her Medical Assistance Identification Card), and whether or not Medicaid/FAMIS/FAMIS MOMS is billed by the provider for rendered services related to the accident, the provider must forward the DMAS-1000 form to the attention of the

Third Party Liability Unit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

(To obtain a copy of this form, see the “Replenishment of Billing Materials” section in Chapter V of this manual.)

ASSIGNMENT OF BENEFITS (RTS)

If an individual enrolled in the Virginia Medical Assistance Program is the holder of an insurance policy which assigns benefits directly to the individual, the facility must require that benefits be assigned to the facility or refuse the request for the itemized bill that is necessary for the collection of the benefits.

USE OF RUBBER STAMPS FOR PHYSICIAN DOCUMENTATION (RTS)

A required physician signature for Medicaid purposes may include signatures, written initials, computer entries, or rubber stamps initialed by the physician. However, these methods do not preclude other requirements that are not for Medicaid purposes. For more complete information, see the *Physician Manual* issued by DMAS and review Chapter VI in this manual for information on medical record documentation and retention for psychiatric services.

FRAUD (RTS)

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain, or items of value for services rendered or supposedly rendered to individuals reenrolled in Medicaid. A provider participation agreement or contract will be terminated or denied when a provider is found guilty of fraud.

Since payment of claims is made from both State and Federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either Federal or State Court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, United States Attorney General, or the appropriate law enforcement agency.

Further information about fraudulent claims is available in Chapter V, “Billing Instructions,” and Chapter VI, “Utilization Review and Control” of this manual.

TERMINATION OF PROVIDER PARTICIPATION (RTS)

The Participation Agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to the expiration of the agreement.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and FH-PEU 30 days prior to the effective date. The addresses are:

Director

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid –PES

PO Box 26803

Richmond, Virginia 23261-6803

DMAS or the BHSA may terminate a provider’s agreement to participate with Virginia Medicaid with thirty (30) days written notification prior to the effective date**.** Such action

precludes further payment by the BHSA for services provided to customers subsequent to the date specified in the termination notice. The MCOs have different rules for terminating providers and shall adhere to the contract rules regarding notification.

Any provider losing JCAHO accreditation will be notified of DMAS termination if their eligibility as an enrolled provider of a specific service required JCAHO accreditation. DMAS can rescind the termination of the provider agreement if accreditation is restored; however, Medicaid reimbursement will not be available for any period during which the provider does not meet DMAS provider participation standards.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a BHSA/Medicaid agreement or contract is terminated or denied to a provider pursuant to the Code of Virginia §32.1-325D and E. The provider may appeal the decision in accordance with the Virginia Administrative Process Act (APA), Code of Virginia §2.2-4000 *et seq.*, the State Plan for Medical Assistance provided for in the Code of Virginia § 32.1-325 *et seq.* and the DMAS appeal regulations at the Virginia Administrative Code 12 VAC 30-20-500 *et seq.* Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial. This only applies to provider contracts with DMAS for fee-for-service or the BHSA. Providers denied or terminated from a MCO network do not have appeal rights with DMAS.

Termination of a Provider Contract Upon Conviction of a Felony

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or

2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

   a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

   b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

   a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the

MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

Member Appeals

Member Appeals (MCO)

Members, their attorneys, or their authorized representatives have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted, or deemed exhausted (due to the failure of the MCO to adhere to the notice and timing requirements), prior to a member filing an appeal with the DMAS

Appeals Division.

Any member, member's attorney, or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO's internal appeal and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at Virginia Administrative Code 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be sent to the Appeals Division through the following methods:

- Accessing AIMS through a secure website at https://vamedicaid.dmas.virginia.gov/. From here, a member or representative can fill out an appeal request, submit documentation, and follow the process of an appeal. AIMS will be available starting in Spring 2021.
- By downloading a Medicaid/FAMIS Appeal Request form from the internet at https://www.dmas.virginia.gov/ or by writing a letter. The appeal request must identify the issues being appealed. The form or letter can be submitted by:

- Mail or delivery to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
- Email to appeals@dmas.virginia.gov, or
- Fax to (804) 452-5454.

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

Member Appeals (FFS)

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an attorney or authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member will be expected to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS Contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS Contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be

postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at www.dmas.virginia.gov or by calling (804) 371-8488. A copy of the notice or letter about the action should be included with the appeal request.

Appeal requests may be sent to the Appeals Division through the following methods:

- Accessing AIMS through a secure website at https://vamedicaid.dmas.virginia.gov/. From here a member or representative can fill out an appeal request, submit documentation, and follow the process of an appeal. AIMS will be available starting in Spring 2021.
- The appeal request form or letter and any additional documentation can be submitted by:
  - Mail or delivery to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
  - Email to appeals@dmas.virginia.gov, or
  - Fax to (804) 452-5454.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as

set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the

appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she

deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

CLIENT APPEALS (RTS)

Member Appeals (MCO)

Members or their authorized representatives have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted or deemed exhausted, due to the failure of the MCO to adhere to the notice and timing requirements, prior to a member filing an appeal with the DMAS Appeals Division.

Any member or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. If the member does not request an expedited appeal, the member must follow an oral appeal with a written, signed appeal. Information about the appeal process must be made accessible to individuals with limited English proficiency and individuals with disabilities.

A member may request continuation of services during the MCO's internal appeal and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at the Virginia Administrative Code 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's

internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be faxed to (804) 452-5454, emailed to appeals@dmas.virginia.gov, or mailed.. If sent by mail, the appeal request should be mailed to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the APA at the Code of Virginia § 2.2-4025, *et seq*. and the Rules of Court.

Member Appeals (FFS)

Members receiving FFS services through a DMAS Contractor may be required to file an internal appeal with the DMAS Contractor before appealing to DMAS. Providers under contract with a DMAS Contractor seeking to file an appeal on behalf of their client should consult their contract with the DMAS Contractor.

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. Information about the appeal process must be made accessible to individuals with limited English proficiency and individuals with disabilities.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member will be expected to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS Contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS Contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. The member or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

Appeal requests may be faxed to (804) 452-5454 or emailed to appeals@dmas.virginia.gov .

If sent by mail, the appeal request should be mailed to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Exhibits (RTS)

SAMPLE ATTESTATION LETTER

(Submit on Facility Letterhead)

This attestation must be signed by an individual who has the legal authority to obligate the facility.

Date

Name of the Psychiatric Residential Treatment Facility

Facility Address

City, State, Zip Code

Telephone Number

Fax Number (if applicable)

Provider Number/NPI

To the Virginia Department of Medical Assistance Services:

The above listed facility has [insert total number of facility beds]. As of the date of this attestation, the facility has [insert number of Medicaid residents in the facility]. Of this total, [insert number of residents for whom the psych under 21 is paid for by another state].

Below is a list of all states from whom the facility has ever received Medicaid payment for the provision of psych under 21 benefit:

[include list]

By this letter, I attest that this facility, a residential treatment facility providing inpatient psychiatric services to individuals under the age of 21, is in compliance with Part 483, Subpart G of CMS's standards governing the use of restraint and seclusion. In the event that there is a new facility director, the facility will submit a new attestation of compliance.

Sincerely,

Name of Individual

Facility Director [insert position name]